Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
TWELVE OAKS MEDICAL CENTER
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-07-2922-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
54

MFDR Date Received
DECEMBER 29, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated December 27, 2006: "…The total sum billed was $113,636.13. There was no on-site audit performed by the insurance carrier…Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ("SLRF") of 75%... the fees paid by Texas Mutual Insurance Company do not conform to the reimbursement section of Rule 134.401."

Amount in Dispute: $54,658.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 1, 2007: "The admission did not have services that were unusually extensive or unusually costly and total audited charges do not exceed the minimum threshold of $40,000. Payment under the stop-loss exception has not been justified by the hospital in this case, and Texas Mutual's payment under the per diem plus carve-outs method is appropriate.

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 4, 2006 through January 6, 2006	Inpatient Hospital Services	$54,658.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated March 24, 2006

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-W10 NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.
- CAC-W4 NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION
- CAC-143 PORTION OF PAYMENT DEFERRED
- CAC-97 PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE
- 420 SUPPLEMENTAL PAYMENT
- 426 REIMBURSED TO FAIR AND REASONABLE
- 480 REIMBURSEMENT BASED ON THE ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE PER DIEM RATE ALLOWANCES
- 730 DENIED AS INCLUDED IN PER DIEM RATE
- 891 THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION

Explanation of benefits dated May 08, 2006

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-W10 NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.
- CAC-W4 NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION
- CAC-18 DUPLICATE CLAIM/SERVICE
- CAC-97 PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE
- 426 REIMBURSED TO FAIR AND REASONABLE
- 480 REIMBURSEMENT BASED ON THE ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE PER DIEM RATE ALLOWANCES
- 730 DENIED AS INCLUDED IN PER DIEM RATE
- 878 DUPLICATE APPEAL. REQUEST MEDICAL DISPTUE REOSLUTION THROUGH DWC FOR CONTINUED DISAGREEMENT OF ORIGINAL APPEAL DECISION
- 891 THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges

exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $113,636.13. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement asserts that "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ("SLRF") of 75%." The requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.

   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $384.00 for revenue code 382 - Blood and $95.00 for revenue code 390 - Blood Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 382 and 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

- The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Charge Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
81336349	Pin Stienman II	Steinmann Pins, Style 6, 2.0MM Diag X 229MM	4 at $42.00 ea	$168.00	$184.80
81389991	Femur Ring	Fem cross section 14MM FD	1 at $530.00 ea	$530.00	$583.00
8138991	Femur Ring	Fem cross section 16MM FD	1 at $542.00 ea	$542.00	$596.20
8138991	TI Locking Cap	TI Click'X locking cap for Ti 3-D head	1 at $242.00 ea	$242.00	$266.20
81389991	TI 3-D Head 6U	TI 3-D Head for TI Click'X screws	1 at $551.00 ea	$551.00	$606.10
8138991	Washers 4UN	Washer 13.0MM	1 at $21.50 ea	$21.50	$23.65
8138991	30MM Screws 4U	No invoice provided	$0.00	$0.00	$0.00
81389991	6.0X75 CRV Rod	6.0MM TI Curved Soft Rod	1 at $242.00 ea	$242.00	$266.20
8138991	7.0X35 Clk Scw	7.0MM TI click'X (TM) pedicle screw 35MM Thread length	1 at $586.00 ea	$586.00	$644.60
81389991	7.0X40 Clk Scw	7.0MM TI Click'X (TM) Pedicle screw 40 MM Threaded length	1 at $586.00 ea	$586.00	$644.60
81389991	8.0X35 Clk Scw	8.0MM TI Click'X (TM) Pedicle Screw 35MM thread length	1 at $586.00 ea	$586.00	$644.60
81952509	Wax Bone 2.5GMS	Bone Wax 2.5 Grams	2 at $50.05 ea	$100.10	$110.11
81312878	Bn Grft Bmp Lg	Infuse Bone Graft Large	1 at $4,990.00 ea	$4,990.00	$5,489.00
			TOTAL ALLOWABLE	$10,059.06	

The division concludes that the total allowable for this admission is $2,236.00 + 10,059.06. The respondent issued payment in the amount of $30,565.79. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled

Standard Per Diem Amount, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/6/12
Signature	Medical Fee Dispute Resolution Officer	Date
		12/6/12
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.